MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH DEPARTMENTS

Submitted to the
Health Resouces and Services Administration
U.S. Department of Health and Human Services

by the

Public Health Foundation
1220 L Street, N.W., Suite 350
Washington, D.C. 20005

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DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

APR 28 1997

Dear Colleague:

I am pleased to forward to you **Measuring Expenditures for Personal Health Care Services Rendered by Public Health Departments,** a study conducted by the Public Health Foundation with support from the Office of Planning, Evaluation and Legislation, Health Resources and Services Administration.

Major developments are causing State and local health departments to re-examine their roles and the way they conduct their business, particularly with respect to health services delivery. The movement to Medicaid managed care is changing the dollar flows that finance personal health services. State government re-engineering is putting a premium on new ways of partnering with the private sector, adoption of performance measurement, and organizational restructuring. Yet, we know little about how health departments spend their money on personal health care--the distribution across meaningful spending categories and the changing structure for delivering services. We hear anecdotally that health departments are "getting out of the business" of personal health services with little capacity to track what is actually occurring in the public marketplace.

The impetus for this exploratory study comes directly from two sources. First is the initiative to develop a standardized framework for analyzing public health functions. DHHS with its partners in the public health community have devised and continue to refine a set of 10 public health services categories and to collect expenditure data according to this classification scheme. Second is the desire to devise a cost-effective way to collect data on public health activities at the State and local level. Currently, DHHS is funding a study to clarify approaches for routine monitoring of public health infrastructure.

Because HRSA's programs are so embedded in or affected by how health departments carry out their personal health services roles in conjunction with population based activities, it was opportune to build on the expenditures work of the Public Health Foundation. The intent was to explore State and government local capacity to report data that would provide insight into how functions are changing. This was not an effort to make estimates for the nation as a whole, but a beginning look at useful ways of thinking about personal health expenditures, devising operational categories, and understanding issues around the feasibility of reporting sufficiently accurate data from the States and localities.

We believe this report is a first step in getting clarity on the specifics of why we want better public health infrastructure data and how we can get it. It poses three broad policy relevant questions: Are there shifts among personal health service spending categories? Are public health personal health services being bundled into more comprehensive sets of services? Are health departments delivering those services in different ways structurally? Trend data will begin to reveal insights such as, whether health departments are contracting more actively on a capitated basis; what the relative emphasis is between primary care versus specialty services or HIV care and family planning, the extent to which health departments are sponsoring HMOs or delivering care in disease specific clinics. Comparisons across health departments in the future will help us better understand whether the size or nature of public health investments make a difference for performance and health outcomes.

Our goal ultimately is to understand how a major element of the delivery system--the public health agency--is changing in the jobs they do for the population in general and the sub-populations for whom HRSA has a special responsibility. Key questions can only be answered with standardized data where there is consensus about how that data serves the common need to get answers that make a difference. As this report reveals, it is possible to make good headway down this road, but the road is not free of barriers. We must accept that this has to be an iterative process where the Federal Government sits at the table with its partners at the state and local level striving for greater clarity of purpose and more accurate data in the service of that purpose. We at HRSA commit to that process.

Sincerely,

Claude Earl Fox, M.D., M.P.H.
Acting Administrator

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ACKNOWLEDGMENTS

The Public Health Foundation (PHF) thanks the many individuals who contributed to this project. We are indebted to the participants of the Personal Health Care Services Work Group of the June 1995 Public Health Expenditures workshop who contributed to the development of the survey instrument. We also recognize staff who served as coordinators in each pilot site-Merrill Krenitz (Arizona), Mike Abkowitz and Thomas Watson (Austin/Travis County, Texas), Karen Fread (Iowa), Perri Leviss and Ann Carroll (New York City), and William Waters (Rhode Island)—who devoted considerable time and effort from their busy schedules. We gratefully acknowledge the officials and staff in the participating agencies for their support and commitment to developing quality data and to providing invaluable feedback on the methodology and on drafts of this report. Special thanks go to Merrill Krenitz for her preparation of the Arizona site visit.

PHF thanks staff at the Health Resources and Services Administration, specifically, Michael Millman, Senior Staff Fellow, for his leadership and guidance in survey design and implementation and report preparation.

EXECUTIVE SUMMARY

The U.S. health care system is undergoing enormous change. In 1993, in the midst of the national health care reform debate, public health professionals became concerned that public health programs and activities were not being considered as essential elements of the system reforms and that ultimately the lack of emphasis on these programs would inhibit public health departments' ability to protect the nation's health. As states moved to fill the void left by the failed national health reform, some concern remained that states were continuing to give low priority to the public health issues of health care reform.

As reform of the health delivery system continues, the way in which public health departments provide services may be significantly affected, making it critical for policy makers, managers, and researchers to be able to assess the impact of changes on the public health components of the health care delivery system. Therefore, the Health Resources and Services Administration (HRSA) commissioned the Public Health Foundation (PHF) to develop a categorization schema for reporting comparable information on state and local health department personal health care services.

The overall goal of this project was to initiate development of and test a methodology to collect consistent and complete expenditure data on state and local health department personal health care services. Personal health care services are those direct health care services provided to individuals, as opposed to population-based health services, which are interventions that prevent disease and promote health among entire populations. This effort complements a parallel effort by the U.S. Public Health Service (PHS) and PHF to characterize public health expenditures by the ten essential public health services (see box below). This study focuses on essential service #6, "Link *people to needed personal health care services and assure the provision of health care when otherwise unavailable,"* testing health departments' ability to estimate expenditures for specific personal health care service categories and delivery methods.

ESSENTIAL PUBLIC HEALTH SERVICES

1. **Monitor health status to identify community health problems**
2. **Diagnose and investigate health problems and health hazards in the community**
3. **Enforce laws and regulations that protect health and ensure safety**
4. **Inform, educate, and empower people about health issues**
5. **Mobilize community partnerships to identify and solve health problems**
6. **Link people to needed personal health services and assure the provision of health care when otherwise unavailable**
7. **Evaluate effectiveness, accessibility, and quality of personal and population-based health services**
8. **Assure a competent public health and personal health care workforce**
9. **Develop policies and plans that support individual and community health efforts**
10. **Research for new insights and innovative solutions to health problems**

Source: **Essential Public Health Services Work Group of the Public Health Functions Steering Committee, Fall 1994**

Officials from 11 state and local health departments as well as one state association of local health officials were selected to help design a survey instrument, including definitions of service categories and service delivery methods. The draft survey instrument was then tested by a sub-sample of those agencies, including state health departments in Arizona, Iowa, and Rhode Island and local health departments in Austin/Travis County, Texas, and New York City, New York. A site visit was also conducted, providing invaluable insight into one participant's experience in implementing the survey. An important element of the test was an evaluation asking participants to document their experiences and assess the strengths and weaknesses of the pilot methodology.

The data generated through this pilot study provide useful and interesting insights into the kinds of personal health care services delivered by health departments and the delivery methods used. Study results demonstrate the diversity in the roles played by health departments, in the services they offer, and in the specific needs of each community. Results also provide preliminary insights into the interrelationships between the public and private sectors in providing personal health care services.

Key lessons were learned involving design and implementation of the methodology. Participants considered the methodology generally clear and potentially useful, with some notable exceptions. Where problems existed, participants offered valuable feedback for improving the methodology. The major limitations of the methodology and data included:

- Response Rate and Data Quality. Only five of the original nine participants were able to complete the survey. Data from one state participant could not be aggregated statewide and were excluded from the summary analysis. Time required to complete the survey varied greatly--between 16 and 120 hours-which may be reflected in data quality.

- Variability in Units of Analysis, Interpretation of Definitions, and Application of Guidelines. Because of the diversity in how health departments are organized, it is difficult to standardize data collection across the units of analysis. Differences between the categories used on the survey and health departments' accounting formats made it difficult for respondents to distribute their expenditures across the categories in a uniform manner.

Recommendations to enhance the data collection methodology include:

Provide strong leadership in the initial implementation stages. Leaders at federal, state, and local levels must demonstrate commitment to and expect quality results from applications of the new methodology.

Minimize additional respondent burden. This personal health care expenditure survey should be combined with the data collection tool developed for capturing essential public health service expenditures. Consideration should be given to reducing the number of categories, both for services and for delivery methods, included in the survey instrument.

Improve respondent perceptions of the usefulness of the survey. Discussion of potential uses of survey results as part of introducing the methodology to respondents would contribute to a better understanding and increased commitment on the part of respondents.

Experiment further with mechanisms to collect local health department data. Discussions should continue with organizations, including the National Association of County and City Health Officials (NACCHO) and the National Association of Local Boards of Health (NALBOH), to develop a mechanism for working with larger samples of local health departments to collect expenditures data.

Further refine survey methodology. Further refinements are required to address difficulties experienced by participants in using the survey instrument. Clearer definitions are required to eliminate overlapping personal health categories. An initial meeting of survey participants, including program managers, would contribute to improved consistency of results between participating health departments.

This project, developed with input from health department officials, offers an initial step toward a method of characterizing health department personal health care services expenditures. Future collection and analyses of these data will help health department managers document the impact on the health department of major policy initiatives such as moving Medicaid beneficiaries into managed care. By establishing a baseline which allows for trend analysis of activities over time, health department officials could have valuable information for establishing their own priorities, monitoring trends in a changing health care environment, and taking appropriate corrective actions in a timely manner. At the federal level, these estimates would contribute to a better understanding of the impact of federal policy changes on state and local levels.

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MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH DEPARTMENTS

I. INTRODUCTION

Historically, uniform information on the amount of investments made to finance public health at the local, state, and federal levels has been hard to come by. A number of attempts have been made over the years to characterize expenditures for public health. However, these efforts did not differentiate between personal health care and population-based health services. Lacking this information has made it increasingly difficult for decision makers to make the case for a strong public health system **in an era** of cost **containment.**

In order to inform policy decisions and begin to monitor the effect these changes are having on the public health infrastructure, baseline estimates of expenditures for essential public health services are needed at federal, state, and local levels. In 1993, the U.S. Public Health Service (PHS) initiated the Public Health Expenditures Project. The Public Health Foundation (PHF), under contract to PHS, developed a methodology for estimating expenditures for what were then called the core public health functions. The core functions were later redefined by a national consensus process to be the ten essential public health services (see box below). This framework emphasized the distinction between personal health care services (direct care services provided to individuals) and population-based health services (interventions that prevent disease and promote health among entire populations). For the sake of analysis in that study, personal health care services corresponded to the second part of essential service #6, 'Assure the *provision of health care when otherwise unavailable."* Population-based health services comprised all other essential public health services.

Figure 1

ESSENTIAL PUBLIC HEALTH SERVICES

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Enforce laws and regulations that protect health and ensure safety
4. Inform, educate, and empower people about health issues
5. Mobilize community partnerships to identify and solve health problems
6. **Link people to needed personal health services and assure the provision of health care when otherwise unavailable**
7. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
8. Assure a competent public health and personal health care workforce
9. Develop policies and plans that support individual and community health efforts
10. Research for new insights and innovative solutions to health problems

Source: Essential Public Health Services Work Group of the Public Health Functions Steering Committee, Fall 1994

The project was implemented in two iterative phases, with the second phase attempting to refine and further test the methods developed in the first phase. State and local health

departments, and mental health, substance abuse, and environmental agencies in nine states-Arizona, Illinois, Iowa, Louisiana, New York, Oregon, Rhode Island, Texas, and Washington-along with U.S. Public Health Service agencies, participated in the second pilot.

Results of this pilot demonstrated the predominance of personal health care services within the public health system (69 percent of a total $8.8 billion spent on the essential public health services supported personal health care services). This, combined with the move of Medicaid beneficiaries to managed care in the private sector and a potential underfunding of the health safety net for the uninsured, indicates a need for a complementary expenditure tool for collecting more detailed information on personal health care services. As public health departments begin to take on new roles in personal health care delivery vis à vis managed care, a mechanism to track these changing roles is critical for effective policy making.

Building on the work to estimate expenditures for the essential public health services, PHF, under a contract with the Health Resources and Services Administration (HRSA), began developing a categorization schema for reporting comparable information on state and local health department personal health care services. This study attempted to capture more detail about all of essential service #6, "Link *people to needed personal health care services and assure fhe provision of* health *care when otherwise unavailable,"* including both the population-based component-enabling services-and the direct care component.

II. GOALS AND OBJECTIVES

The overall goal of this project was to begin developing and testing a methodology to collect consistent and complete data on state and local health agency expenditures for personal health care services to enable policy makers, managers, and researchers to assess the impact of changes in the health care delivery system.

Objectives for the HRSA-funded study included:

- Develop categories of personal health care services that provide critical information for answering policy questions under health care reform, taking into account local, state and federal perspectives;
- Determine the extent to which consistent and complete information can be collected across states using agreed upon definitions;
- Document the nature of the information sources and the processes for extracting data at the state level; and
- Assess the potential for and level of investment required to obtain data from sub-state public health departments.

State and local health departments present a wide spectrum of health care delivery methods, ranging from categorical services delivered through health department-run clinics, to a mix of health department and managed care delivery, to functioning as managed care organizations. When fully implemented, the results of this expenditure survey will demonstrate:

- The extent to which public health personal health care services are being bundled into comprehensive services;

- Shifts among personal health service spending categories; and

- Shifts in the way health departments are delivering those services.

Once consistent estimates are available, policy makers will have better information for their discussions regarding the role of health departments in providing health care services for their populations. Periodic estimates of personal health care services delivered by health departments will allow policy makers to track changes in the relative priorities given to the various health services and in the delivery methods for provision of these services. At the federal level, these estimates would contribute to a better understanding of the impact of federal policy changes on state and local levels.

III. METHODOLOGY

Officials from 11 state and local health departments and one state association of local health officials helped develop a survey instrument, including definitions of service categories and service delivery methods. The draft survey instrument was then tested by a sub-sample of those agencies, including state health departments in Arizona, Iowa, and Rhode Island and local health departments in Austin/Travis County, Texas and New York City, New York, with on-going assistance provided through telephone contact by PHF. A site visit was also conducted, providing invaluable insight into one participants experience in implementing the survey. An important element of the test was an evaluation asking participants, based on their experiences with using the pilot methodology, to assess the strengths and weaknesses of the tool. PHF compiled and analyzed the data for each site as well as across the sites.

Figure 2

METHODOLOGY

1. Site selection
2. Collaborative survey design and refinement
3. Methodology testing with technical assistance from PHF
4. Evaluation of methodology by participants
5. Site visit
6. Compilation/analysis of the data

Site Selection **and Collaborative Survey Design and Refinement**

State health departments in Arizona, Illinois, Iowa, Louisiana, Rhode Island, and Washington and local health departments in Austin/Travis County, Texas, Multnomah County, Oregon, and

New York City, New York originally agreed to participate in the pilot phase of this survey. Unlike the Public Health Expenditures Project, local health departments were targeted directly, given that they are the predominant providers of publicly-funded personal health care services and that the methods in which they deliver personal health care services vary greatly among localities (direct health department provision of personal health care services vs. managed care arrangements, for example). These states and localities were selected because of their participation in the Public Health Expenditures Project and the need to test the consistency between the two studies. In addition, these health departments serve populations with different demographic characteristics and provide different levels of personal health care services. Four of the nine sites-Illinois, Louisiana, Multnomah County, and Washington-did not test the data collection instrument. (See Limitations for further discussion.)

The process of designing the methodology was a collaborative one. As part of a one-day workshop held in June 1995 in conjunction with the Public Health Expenditures Project, state and local health officials from the nine sites, associations' staff, federal officials, and others representing related projects contributed to the design of the methodology (see Appendix II for the list of participants in the personal health care Workgroup). One break-out session focused on personal health care services, where participants discussed the draft survey tool and guidelines presented by PHF. Participants made valuable recommendations on delivery methods, service categories, and associated definitions. While it was not possible to define terms to fit all health department accounting structures, this process helped to ensure that the most common definitions used by health department staff were reflected in the tool. The meeting helped to improve understanding of the objectives of the project and commitment to the process.

Prior to implementation, participants were provided another opportunity to comment on the survey instrument. PHF sent the final survey instrument to the participants in April 1996, with an eight-week deadline **for completion.**

Testing the Methodology and Participant Evaluation

The data collection effort was designed to last eight weeks; however, it took between eight weeks and four months. During this time, PHF provided assistance to state and local representatives with regard to methodological procedures and assignment of expenditures to specific categories.

Participants were asked to report total FY '95 expenditures for their health department for personal health care services by service category. Definitions for each service category were provided to assist in deciding how to categorize expenditures (see Appendix I, Part 2, Attachment B). Where necessary, participants could add categories if no existing category fit their accounting structure. Budget figures could be reported if actual expenditures were not available.

Total expenditures were then apportioned by percentages according to delivery method. As part of the data collection instrument, definitions for each delivery method were provided (Appendix I, Part II, Attachment C). Administrative expenses supporting specific personal health care services, including client-based data systems, were included under those specific services. General administrative expenses of the health department that support all health department functions and programs were excluded.

For state health agency participants, total expenditures reported for this complementary survey should approximate and delineate the amount reported under essential service #6 of the Public Health Expenditures Project.

Finally, participants were asked to document their experiences with using the pilot methodology in an effort to improve future iterations. The evaluation asked for feedback in four areas: 1) the process used to collect the data; 2) design of the data collection instruments; 3) sources of information and reliability of estimates; and 4) overall assessment of the process.

Site Visit - Arizona Department of Health Services

PHF conducted a site visit to one of the survey sites to better understand the problems and general experiences of implementing the survey. The Arizona Department of Health Services (ADHS) was chosen for several reasons which are enumerated under the Arizona Department of Health Services profile (page 22). An interview protocol (see Appendix Ill) was developed for use during the site visit. Because some divisions in ADHS did not fully complete the survey, statewide Arizona data are excluded from the analysis. However, a summary of the site visit is included in the Arizona "Participant Profile," because valuable lessons were learned for future iterations of the survey. In addition, data from the Behavioral Health Services division of ADHS are profiled.

Limitations

The data generated through this pilot study provide useful and interesting insights into the kinds of personal health care services assured by health departments and the delivery methods used. They should, however, **be used with caution, given the limitations of the study.** As with the Public Health Expenditures Project, some of these limitations are inherent to any study that deals with a variety of non-standardized health department structures. Other limitations resulted from the design of the methodology and must be addressed in future iterations of the survey.

Response Rate and Data Quality. The response rate to the survey was weaker than anticipated because of a variety of factors, including the timing, burden, and lack of agreement on the utility of the survey. Only five of the nine pilot sites that originally agreed to participate actually provided data. The five participants who completed data collection may have experienced similar problems juggling existing workloads with the data collection effort. Time committed to complete the survey varied greatly-between 16 and 120 hours-which may be reflected in data quality.

Variability in Units of Analysis. Interpretation of Definitions, and Application of Guidelines. Although definitions for categories were developed and reviewed by health department officials, variation existed in application of guidelines and in assigning expenditures to specific categories. Organizational differences between health departments was also a factor that made comparisons across sites problematic. For example, some states include mental health and substance abuse in health departments, while other states offer these services in separate agencies. In addition, health departments do not follow the same fiscal years; therefore, data submitted may reflect different periods of time. Use of expenditure data by some health departments and budget data by others introduced additional variation.

Difference between Survey Format and Health Department Accounting Practices. Variety exists in the way health departments organize their services and associated accounting structures. Iowa uses cost center accounting and therefore experienced problems in dividing its "health promotion" cost center into its component parts: prenatal, postpartum, and communicable disease visits. New York City's Bureau of HIV Program Services had difficulty breaking out HIV counseling/early intervention activities from the broader category of "health education." Other examples of problems cited by participants included:

- Prenatal care delivered in a home health setting could be assigned to either prenatal care (service #9 of the survey instrument) or to home health services (service #21 of the survey instrument).

- Overlap of activities between the Public Health Expenditures Project and the personal health care expenditure survey caused additional confusion. For example, partner notification and contact tracing activities are listed as part of essential service #2 (Diagnose and investigate health problems and health hazards in the community). These activities are also listed as part of personal health care services under #17 (STD clinics).

Where a program/service had multiple funding sources which were separately accounted for, expenditures might be underreported where participants chose to report only one source for this survey. Data quality appeared to improve where finance staff were involved with service managers in survey completion.

Incomplete Data. Data from Arizona were fragmented (i.e., only some units of the state health department and approximately half of the county health departments responded to the survey) and could not be aggregated at the state level; therefore these data were not used in analysis of survey results. As the Division of Behavioral Health Services provided an exceptionally complete response, a summary of its results is included as part of the Arizona Profile.

IV. OVERVIEW OF RESULTS

This overview sets out brief descriptions of the four participants (two state and two local health departments) for which data could be analyzed, discusses each in the context of a continuum of health service delivery methods, and displays expenditure results by service group and by delivery mechanism. This section is then followed by profiles of each of these four participants and of the Arizona site visit.

Figure 3

PROFILES

Local Health Departments

- Austin/Travis County, Texas
- New York City, New York

State Health Departments

- Iowa
- Rhode Island

Arizona Site Visit

Austin/Travis County Health and Human Services Department estimated spending $44.8 million for personal health care services in FY 1995, serving a population of approximately 660,000 people (1995 estimate) in Austin and surrounding Travis County. Personal health care services represent nearly 50 percent of the total health department budget.

The Iowa Department of Public Health estimated $50.1 million in total expenditures, based on an extrapolation from a sample of 10 of 99 local health departments. Services are available to the 2.8 million Iowans, most who live mainly in rural areas. Substance abuse and mental health services are not provided by local health departments in Iowa.

New York City, with the largest number of Medicaid eligibles in the country, estimated expenditures of $244.5 million, serving a total population of well over 7 million (1990 census estimate). Expenditures for personal health care services represent 57 percent of total health department expenditures, including Correctional Health Services (29 percent of total personal health care expenditures).

The Rhode Island Department of Health estimated $7.2 million in expenditures for personal health care services for a population of 990,000. The Rhode Island Department of Health has little responsibility for direct provision of personal health care services. Many personal health care services for uninsured populations in Rhode Island are provided through community health centers. There are no local health departments in Rhode Island and, at the time of the survey, both substance abuse and mental health services were not provided by the Department of Health.

Participants considered the methodology generally clear and potentially useful, with some notable exceptions. It is clear from participant evaluations that problems were encountered in trying to fit personal health care services into survey categories due to differing accounting approaches. Completion of the survey required that broad personal health care services be broken down into component parts or vice versa. Where problems existed in applying the methodology, participants offered valuable feedback for improving the methodology.

One way of examining expenditure results is to think of the participating health departments as being on a continuum of health service delivery methods, with direct health department categorical services and fully capitated managed care (public or private) at the two extremes, and increasing use of contracted, comprehensive, or capitated services between the two extremes. For the sake of this study, it is assumed that use of capitation and the bundling of discrete services into comprehensive care are characteristics of reform; whereas, non-capitated, health department categorical clinical services are assumed to be characteristic of more traditional health departments.

Participants were provided the following definitions for personal health care service delivery methods:

- Public managed care organization - health department owned and operated managed care organization (MCO)
- Health department-run comprehensive clinics - a wide range of services provided by the health department, either on a non-capitated or capitated basis
- Contracted services - health department pays for specific services provided by an outside contractor (non-capitated) or for primary care services by an MCO (capitated)
- Health department-run categorical clinics or services - public health clinics provide specialized care

The extent to which health departments bundled services (services delivered as a package) or provided discrete services (services provided separately; i.e., not as a package) was also recorded on the data collection instrument. Bundled services include comprehensive primary care services and comprehensive personal health care services, which include both primary care and specialty health services delivered on an inpatient or outpatient basis. Discrete services were divided between primary medical, specialty health, other professional health, inpatient, and enabling services.

Among survey respondents, Austin/Travis falls furthest toward the managed care end of the service delivery continuum, given some comprehensive (bundled) services, a substantial portion of contracted services, and a small amount of capitation. Rhode Island assures the delivery of services almost exclusively by contracting out, offers no comprehensive health services, but does offer a small amount of services on a capitation basis. It therefore falls somewhere to the left of Austin/Travis on the service delivery continuum. New York City offers a substantial portion of health services by contracting out, but does not bundle comprehensive services or use capitation. Iowa falls furthest to the left on this continuum, as it delivers all services directly, offers no bundled services, and does not use capitation.

Examining expenditures for state health department participants in this sample reveals that Iowa provides 100 percent of personal health care services directly through local health department-run categorical clinics. Rhode Island, on the other hand, has no local health departments and contracts for 99 percent of its services. Neither offer any bundled, comprehensive personal health care services. Looking at the two local health departments–Austin/Travis and New York City-reveals a similar mix of department-run (64 and 57 percent respectively) and contracted services (36 and 43 percent respectively).

V. PARTICIPANT PROFILES

Austin/Travis County Health and Human Services Department (Texas)

Overview

Austin/Travis County Health and Human Services Department (ATHHSD) estimated a total of $44.8 million in FY '95 for a wide variety of personal health care services provided either directly (64 percent) or through contracted services (36 percent). A small proportion (1 percent) of. these services were delivered on a capitation basis. A significant portion (41 percent) of total expenditures were bundled into Comprehensive Personal Health Services (3.3%) and Primary Care Services (37.4%), with the remaining 59 percent spent on discrete health care services. Other Professional Health Services followed with 16 percent of total expenditures, spent mainly on WIC and home health services. In-patient Services accounted for 9 percent of total personal health care service expenditures.

From the information provided, ATHHSD would appear to be typical of a traditional health department with some characteristics of reform. Most services are provided directly by the department on a non-capitated basis. However, many of the health department's services are contracted out and/or bundled (some on a capitated basis), characteristics often associated with health reform.

Expenditures bv Service Group

Comprehensive Personal Health Services cover services provided to participants in the Medical Assistance Program (MAP) and include adult, pediatric, and maternity care delivered on an outpatient basis. Comprehensive Primary Care Services include services associated with the operation of the ATHHSD 13 primary care health clinics, including adult, pediatric, maternity, dental care, pharmacy, laboratory, radiology, and medical social counseling. The Primary Medical Services group includes contracted specialty services (such as pathology and radiology) for MAP-eligible residents. The largest expenditure was for HIV early intervention and treatment ($2.9 million), followed by immunizations ($1.0 million). Family planning services accounted for the smallest individual expenditure category in this group ($9,334), although family planning services are provided as part of Comprehensive Primary Care Services. No prenatal care or pediatric clinic expenditures are included in this category as they are delivered as part of Comprehensive Primary Care Services.

ATHHSD added the category "outpatient specialty services" to the Specialty Health Services group, the largest expenditure ($2.1 million) in that category. STD clinics accounted for the least ($0.5 million) in this category. Ob/Gyn services are not delivered as a discrete service but are included as part of overall Comprehensive Primary Care Services. WIC programs represented 40 percent of Other Professional Health Service expenditures, followed by home health services (35 percent). Nutrition services, which target the elderly, accounted for $40,309 in expenditures and are contracted through local social service agencies. Child care resources services are contracted through local care centers and accounted for $0.2 million. The largest expenditure in the Enabling Services group was for eligibility assistance ($0.8 million), followed by outreach ($0.7 million) and case management ($0.5 million). "Legal aid" was added as a service category with $0.2 million in expenditures, and involves services contracted through local law firms that provide assistance in access to medical and social services.

Distribution of expenditures by groups of services is set out in Table 1.

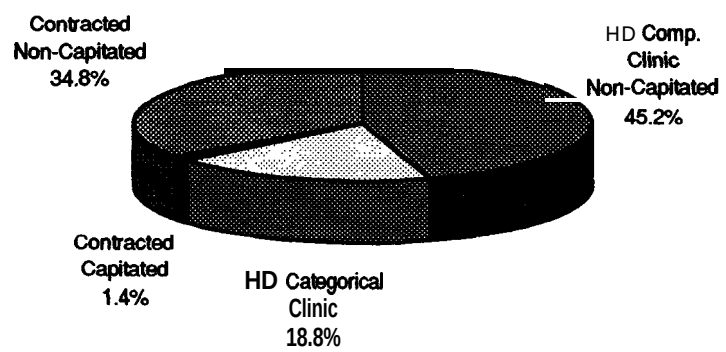
Table 1. Austin/Travis County Personal Health Care Expenditures by Service Group

Service Group	Expenditures (000s)	Percent
Comprehensive Personal Health Care Services	$1,489	3.3
Comprehensive Primary Care Services	16,782	37.4
Primary Medical Services	5,807	13.0
Specialty Health Services	5,145	11.5
Other Professional Health Services	7,266	16.2
Inpatient Services	3,990	8.9
Enabling Services	4,353	9.7
TOTAL	$44,830	100.0

Expenditures by Delivery Method

ATHHSD assured the provision of personal health care services either by directly providing the services in comprehensive (45 percent) or categorical (19 percent) clinics, or by contracting for services, both on a non-capitated basis (35 percent) and on a capitated basis (1 percent). Figure 4 displays the distribution of expenditures by delivery methods.

Figure 4
Austin/Travis County Personal Health Expenditures by Delivery Method



Total: $44.8 million

Service Groups by Delivery Methods

The only service group in which some services were provided on a capitated basis was Comprehensive Personal Heath Care Services. This category was divided between direct provision (56 percent), capitated contracted services (42 percent), and non-capitated contracted services (2 percent). Comprehensive Primary Care Services were offered in health department-run comprehensive clinics (94 percent) and through contracted services (6 percent).

All categories in the Primary Medical Services group were delivered through one delivery mechanism, with the exception of HIV early intervention and treatment, which was divided between health department categorical clinics (40 percent) and non-capitated contracted services (60 percent). The large proportion of contracted services for HIV intervention and treatment may be a result of Ryan White CARE Act funding, which stipulates community participation in service provision. Services within the Specialty Health Services group were delivered through two methods: STD clinics and other specialty medical care through health department-run categorical clinics and children's rehabilitation services and outpatient care on a contracted, non-capitated basis. All Other Professional Services were delivered on a contracted, non-capitated basis, with the exception of WIC, all of which was delivered through health department-run categorical clinics, and home health services (97% in health department-run categorical clinics and 3% on a contracted, non-capitated basis).

In-patient Services were delivered solely on a contracted, non-capitated basis. Enabling Services were delivered on a contracted, non-capitated basis with the exception of case management and eligibility assistance, which were divided between health department-run comprehensive clinics and contracted, non-capitated services. Health education and outreach were split between health department-run categorical clinics and contracted, non-capitated services. Percent allocations for service groups by delivery method are set out in Table 2.

Evaluation of Survey Instrument and Guidelines

The survey was completed by two financial analysts in the Financial Services Division and required 16 hours to complete the exercise. Program staff were not included in the exercise. Evaluators found the survey instrument easy to use, with clear instructions and definitions. They suggested that, given the financial nature of input, a software spreadsheet package would be more appropriate than word processing software. Audited financial reports for FY '95 were used, leading to a high degree of reliability in the estimates.

The overall data collection exercise was found to be a positive one. Potential benefits include comparisons of expenditures to other similar sized city/county health departments.

Table 2. Austin/Travis County Personal Health Care Services, By Service Group and Delivery Method (by percent of total spending in the service group)

Group	Public MCO	Health Department Comprehensive Clinic		Health Department Categorical Clinic	Contracted		Total
		Capitated	Non-Capitated		Capitated	Non-Capitated	
Comprehensive Personal Health Services			55.8		41.9	2.3	100.0
Comprehensive Primary Care Services			94.0	-	-	6.0	100.0
Primary Medical Services				42.3	-	57.7	100.0
Specialty Health Services			-	36.3	-	63.7	100.0
Other Professional Health Services	-		34.0	39.9	-	26.1	100.0
Inpatient Services	-					100.0	100.0
Enabling Services	-		27.8	25.1	-	47.1	100.0

Iowa Department of Public Health

Overview

The Iowa Department of Public Health (IDPH) estimated FY '96 expenditures by extrapolating from a random sample of 10 of 99 local health departments to the state level. The 10 health departments were voluntary participants and may not be representative of the state as a whole. IDPH reported a total of $50.1 million in FY '96 to provide a limited number of personal health care services directly through local health departments. The considerable difference between this estimate and that from the Public Health Expenditures Project ($41 million in FY '95) for personal health care services most likely can be ascribed to different samples of counties used to extrapolate to the state level.

The service group Other Professional Health Services accounted for the largest proportion (70 percent) of total IDPH personal health care expenditures, almost exclusively spent on home health services. Enabling services followed with 21 percent of total expenditures, spent mainly on homemaker/aide assistance, case management, and health education.

From the information provided, Iowa falls at one end of the continuum of delivery methods, with all services provided directly by the health department on a non-capitated basis. The 10 local health departments sampled reported no bundled, comprehensive services nor use of capitation. The rural nature of Iowa, which can be associated with underserved primary care areas, may explain the emphasis on home health services (70 percent of total personal health care expenditures) and homemaker/aide assistance (16 percent of total expenditures).

Expenditures by Service Group

The sampled local health departments in Iowa reported all personal health care services as discrete services. However, IDPH had to unbundle some services (e.g., health promotion) to fit expenditures into the survey's discrete service categories (see Evaluation of Survey Instrument and Guidelines for more detail). The distribution of expenditures by groups of services is presented in Table 3.

Table 3. Iowa Personal Health Care Expenditures by Service Group

Service Group	Expenditures (000s)	Percent
Comprehensive Personal Health Care Services		
Comprehensive Primary Care Services		
Primary Medical Services	$3,786	7.6
Specialty Health Services	490	1.0
Other Professional Health Services	35,147	70.2
Inpatient Services		
Enabling Services	10,627	21.2
TOTAL	**$50,050**	**100.0**

Within the Primary Medical Services group, the largest expenditure was for pediatric clinics ($1.4 million), followed by immunizations ($1.3 million). School health services accounted for the smallest portion ($0.1 million), while no expenditures were reported for family planning services and emergency medical care. The category "Senior Health" was added to the Specialty Health Services group, accounting for $0.3 million (62 percent of total Specialty Health Services expenditures). In fact, there is a legislative appropriation for senior health clinics, which provide comprehensive health assessments, referrals, follow-up, and health promotion/education for the population over age 55. STD clinics accounted for the smallest expenditure category ($3,000) in this group. Almost 100 percent ($35.1 million) of Other Professional Health Service expenditures went to pay for home health services. There were no expenditures for substance abuse or mental health services because the local health departments do not deliver these services. The largest expenditure in the Enabling Services group was for homemaker assistance ($7.8 million), followed by case management ($0.9 million), and health education ($0.7 million).

Expenditures by Delivery Method

The 10 local health departments sampled in Iowa assured the provision of personal health care services through direct provision in categorical health department-run clinics. Table 4 sets out expenditures by delivery methods.

Table 4. Iowa Personal Health Care Expenditures by Delivery Method

Delivery Method	Expenditures (000s)	Percent
Public managed care organization		
Health department-run comprehensive clinics		
capitated		
noncapitated		
Health department-run categorical clinics	50,050	100.0
Contracted service		
capitated	-	
non-capitated		
TOTAL	**$50,050**	**100.0**

Service Groups by Delivery Methods

All services in the sampled health departments were delivered through one delivery method—categorical health department-run clinics.

Evaluation of Survey Instrument and Guidelines

The IDPH Director encouraged local health departments to participate in the pilot test, which was coordinated by the Community Services Bureau. IDPH supervisors and the Assistant Director were involved in the data collection effort, using cost analyses by program to determine personal health care service expenditures. Approximately 100 hours were required for technical assistance to local health departments and report preparation. Local health departments dedicated between four and eight hours each to the exercise.

Respondents considered the instructions generally clear, but found the project overview to be complicated. Difficulties were experienced in identifying administrative expenses not attributable to any specific personal health service. An additional concern was expressed over breaking out health department cost centers, e.g., "health promotion," into separate services listed on the form (prenatal, postpartum, and communicable disease). The decision was made to include all health promotion expenditures in Ob/Gyn, since health promotion activities related to TB were minimal and the highest percentage related to postpartum visits.

IDPH used data that had already been collected for the department's cost analysis. This analysis breaks out program time, salarries, and fringe benefits, multiplied by percent of total wages. The HCFA 1728 (cost report for Medicare) was also used.

Respondents requested that the glossary be improved to reduce differences in language between the survey instrument and IDPH's cost categories. Given the difference between IDPH financial recordkeeping formats and that sought in this survey, technical assistance would be required to introduce this new concept on a wider basis. Timing of the exercise caused a problem, as it fell after the close of FY '95 and before completion of FY '96.

Respondents felt that this would be a good tool to highlight funding shifts from health department to managed care service delivery, once managed care becomes more pervasive in Iowa.

New York City Department of Health

Overview

The New York City Department of Health (NYCDOH) estimated spending $244.5 million in FY '95 for a wide variety of personal health care services provided either directly (57 percent) or through contracted services (43 percent). No services were delivered on a capitated basis. Only 17 percent of total expenditures were delivered as Comprehensive Primary Care Services, with the remaining 83 percent spent on discrete health care services. A substantial portion of total expenditures (29 percent) was for contracted services to correctional institutions.

The service group Enabling Services received the largest allocation (42 percent) of total NYCDOH expenditures, followed by Comprehensive Primary Care Services (17 percent) and Specialty Health Services (17 percent), spent mainly on other specialty medical care (76 percent of total expenditures in this group). Five service groups/discrete services accounted for 70 percent of total personal health care expenditures: Comprehensive Primary Care (17 percent), outreach (16 percent), health education (13 percent), a special needs children program (13 percent), and case management (11 percent).

Expenditures by Service Group

Within the Primary Medical Services group, the largest expenditure was for diagnostic laboratory and X-ray procedures ($13.2 million), followed by HIV early intervention and treatment ($4.2 million), and diagnostic test/screenings (professional component - $4.0 million). No expenditures were reported for family planning services in this group, but, as explained in the evaluation, these expenditures were included under case management. Other specialty medical care (TB, correctional health, and special needs children program) accounted for the largest expenditures ($31 .1 million) in the Specialty Health Services group, followed by STD clinics ($9.0 million). No genetic services were offered.

Pharmacy costs represented 36 percent of Other Professional Health Service expenditures, followed by dental care (22 percent), substance abuse treatment/counseling (21 percent), and mental health (18 percent). Substance abuse treatment/counseling and mental health were delivered only as part of the correctional health services. No expenditures were recorded for occupational, physical, and speech therapy services. The largest expenditure in the Enabling Services group was for outreach ($39.9 million), followed by health education ($31.8 million) and case management ($26.0 million). Services for which no expenditures were recorded

included discharge planning, employment/education counseling, food bank/delivered meals, homemaker/aide assistance, or nursing home and assisted living placement.

Distribution of expenditures by groups of services is presented in Table 5.

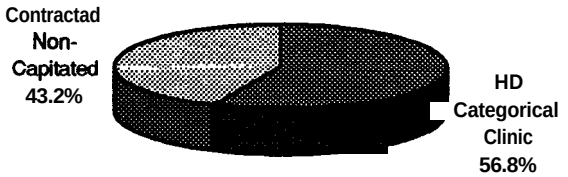
Table 5. New York City Personal Health Care Expenditures by Service Group

Service Group	Expenditures (000s)	Percent
Comprehensive Personal Health Care Services		
Comprehensive Primary Care Services	$42,500	17.4
Primary Medical Services	26,829	11.0
Specialty Health Services	41,047	16.8
Other Professional Health Services	32,143	13.1
Inpatient Services	187	0.1
Enabling Services	101,748	41.6
TOTAL	$244,454	100.0

Expenditures by Delivery Method

NYCDOH assured the provision of personal health care services either by direct provision (57 percent) or by contracting for services (43 percent), all on a non-capitated basis. Of these contracted services, 67 percent were provided to correctional institutions. Figure 5 displays expenditures by delivery methods.

Figure 5
New York City Personal Health Expenditures by Delivery Method



Total: $244.5 million

Service Groups by Delivery Methods

NYCDOH provided no services on a capitated basis. Comprehensive personal health care services were exclusively contracted out. Primary medical services were delivered through department-run categorical clinics (70%) or were contracted out (30%). Within Other Professional Health Services, dental care, home health services, substance abuse treatment/counseling and mental health treatment/counseling were contracted out; nutrition services were provided through health department-run categorical clinics and pharmacy was split between health department-run (2%) and contracted services (98%). All In-patient services were contracted out. Services within the Enabling Services category which were delivered directly by the health department itself included child care, eligibility assistance, health education, interpretation/translation services and development of primary care services in underserved communities. Housing assistance was completely contracted out, while case management, outreach, and transportation were delivered through a combination of direct health department provision (98%) and contracting out (2%). Percentage distributions by service groups and by delivery method are set out in Table 6.

Table 6. New York City Personal Health Care Services, By Service Group and Delivery Method (by percent of total spending in the service group)

Group	Public MCO	Health Department Comprehensive Clinic		Health Department Categorical Clinic	Contracted		Total
		Capitated	Non-Capitated		Capitated	Non-Capitated	
Comprehensive Personal Health Services				-			
Comprehensive Primary Care Services				-		100.0	**100.0**
Primary Medical Services			- .	69.9		**30.1**	100.0
Specialty Health Services				**45.7**		**54.3**	100.0
Other Professional Health Services				**3.8**		**96.2**	100.0
Inpatient Services						100.0	100.0
Enabling Services				98.3		**1.7**	100.0

Evaluation of Survey Instrument and Guidelines

Process

The survey was coordinated by the NYCDOH Bureau of Policy and Planning which tailored the survey instrument to the specific programs of each bureau within the department.

Respondents were given definitions for each service category and asked to enter the percentage of their total FY '95 expenditures for each category and to designate service delivery methods. Upon receipt of completed surveys, the Bureau of Policy and Planning used FY '95 program financial reports to translate percentages back to actual expenditures.

Approximately 120 hours were spent on this exercise by bureaus and in the Bureau of Policy and Planning in formatting individual bureau surveys and in constructing the final spreadsheet.

Instrument Design

Respondents felt that the survey instrument as adapted by the Bureau of Policy and Planning helped avoid confusion since it was tailored to each bureau's needs. However, some confusion remained and included:

- Overlap between personal health care services and other essential public health services; e.g., partner notification and contact tracing activities are part of essential service #2 *(diagnose and investigate health problems and health hazards in the community)* and of personal health care service #17 (*STD clinics - partner notification).*
- Personal health care service #7 (HIV *ear/y intervention and treatment)* includes CD4 counts which should more appropriately be included in #3 *(Diagnostic laboratory and x-ray procedures).*

Decision Rules

In cases where a service category could serve a dual function, programs were asked to include only those expenditures relevant to the category. For example, the lead poisoning prevention program both manages the clinical progress of identified children and sends sanitarians to the children's homes to undertake an environmental assessment. Only the former activity was included under #30 *case management.*

The survey instrument asked for a level of detail which some program managers could not provide. The following are examples where detailed survey categories of services could not be isolated from broader categories:

- HIV counseling/early intervention could not be isolated from the broader category of *health education* #36;
- Family planning services could not be isolated from *case management* #30; and
- Contracted payments to hospitals for clinical services for handicapped and chronically ill children, which included both diagnostic and treatment services, could not be isolated from *children's rehabilitation services* #16 or *other medical services* #18.

In response to requests for guidance in these cases, project staff instructed respondents to assign all expenditures to the broader category.

Where difficulty arose in assigning a service either to a function or a method, e.g. *prenatal care* #9) delivered through *home health services* (#21), respondents were asked to designate expenditures to the functional category, i.e., prenatal care.

Sources/Reliability

FY '95 financial reports prepared by the NYCDOH Bureau of Finance were used to determine expenditures. NYCDOH considers these data to be highly reliable. The approach used by bureaus to categorize expenditures varied according to each bureau's decision to assign expenditures to broad categories or to the more detailed service categories. This variation could be reduced in the future by providing more detailed guidance for decision rules at the beginning of the process.

Overall Evaluation

NYCDOH respondents were somewhat confused about the distinction between personal and population-based activities. One way to clarify this would be to implement the Public Health Expenditures Project and the personal health care services expenditure survey simultaneously or combine the two.

Experience gained in implementing the pilot survey and modifications made in response to feedback will ensure that future iterations are improved. Respondents felt that the exercise was useful in their present attempts to assess and define core and non-core activities performed at the local level. Adoption of the survey for routine use would enable the Bureau of Policy and Planning to work with bureaus to format their expenditure/budget data in a manner more consistent with the survey methodology. In addition, this experience will facilitate New York City participation in a statewide review of essential public health services in local health departments.

Because distinction between personal health care and other health department services had not been considered previously within the department, the department is now able to determine that 49-57 percent (depending on whether personal health care services delivered in correctional facilities are included or not) of total department expenditures were spent on personal health care services. The data also showed that large percentages of personal public health expenditures were for services other than direct clinical services. For example, within personal services, enabling services accounted for 23 percent of expenditures. This information was of specific interest to the Commissioner, showing the extent to which NYCDOH links people to services for their own needs and the public health needs of the population generally.

Rhode Island Department of Health

Overview

Rhode Island Department of Health (RIDOH) spent a total of **$7.2** million in FY '95 on a wide variety of personal health care services, mainly on a contract basis (98 percent non-capitated and 2 percent capitated). An extremely small proportion (0.1%) was delivered directly through RIDOH-run categorical clinics. No services were offered as a package of comprehensive personal health or primary care services.

The service group Enabling Services accounted for the largest proportion (32 percent) of total RIDOH personal health care expenditures, mainly for outreach (42 percent of this group).

Primary Medical Services followed with 29 percent of the total, spent mainly on HIV early intervention and treatment (37 percent). In fact, HIV early intervention and treatment accounted for the largest of all service expenditures (11 percent of total expenditures).

The Rhode Island Department of Health is atypical in that there are no local health departments in the state. This may explain the high proportion of contracted services and reflects RIDOH's role as assurer, rather than provider, of health care. RIDOH is beginning to experiment with capitated services for prenatal care, of which 69 percent were capitated and 31 percent were delivered on a fee-for-service basis.

Expenditures bv Service Group

No personal health care services offered by RIDOH were provided as a package of comprehensive services; 100 percent of services were delivered as discrete services.

Within the Primary Medical Services group, the largest expenditure was for HIV early intervention and treatment ($0.8 million), followed by pediatric clinics ($0.4 million). No expenditures were recorded for urgent medical care. Other specialty medical care (TB clinics) accounted for the largest expenditure ($0.6 million) in the Specialty Health Services group, with STD clinics spending the next largest amount ($0.5 million). Nutrition services represented 30 percent of Other Professional Health Service expenditures, followed by occupational, physical, or speech therapy (25 percent) and pharmacy (19 percent). No expenditures were recorded for substance abuse or mental health services because these services were offered by other agencies at the time of the survey. A small amount ($27,000 or 2 percent) was spent on "rape crisis" services, a self-reported category under Other Professional Health Services. The largest expenditure in the Enabling Services group was for outreach ($1 million), followed by health education ($0.6 million), and case management ($0.4 million).

Distribution of expenditures by groups of services is set out in Table 7.

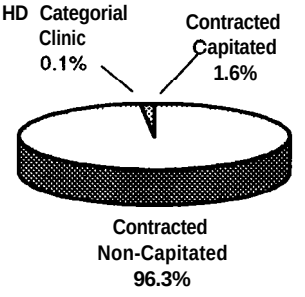
Table 7. Rhode Island Personal Health Care Expenditures by Service Group

Service Group	Expenditures (000s)	Percent
Comprehensive Personal Health Care Services		
Comprehensive Primary Care Services		
Primary Medical Services	$2,099	29.0
Specialty Health Services	1,626	22.4
Other Professional Health Services	1,214	16.8
In-patient Services		
Enabling Services	2,301	31.8
TOTAL	**$7,240**	**100.0**

Expenditures by Delivery Method

RIDOH assured the provision of personal health care services mainly by contracting on a fee-for-service basis (98 percent). An additional 2 percent represent contracted, capitated services. Only 0.1 percent of expenditures were incurred by RIDOH-run categorical clinics. Figure 6 displays expenditures by delivery methods.

Figure 6
Rhode Island Personal Health Expenditures by Delivery Method



Total: $7.2 million

Service Groups by Delivery Methods

While RIDOH delivered personal health care services almost exclusively on a contracted, non-capitated basis, two services were delivered through more than one delivery method. RIDOH provided 69 percent of prenatal services on a capitated basis. However, this represented only 2 percent of total expenditures. The one service offered directly by the RIDOH is dental care; although only 9 percent of expenditures for this service were for services delivered directly by the health department, with the remaining 91 percent contracted out. Percentage distributions for service groups by delivery method are set out in Table 8.

Evaluation of Survey Instrument and Guidelines

Office chiefs completed the exercise, which was coordinated by the Office of Health Systems Development (OHSD). Thirty-five hours were required for this effort, including technical assistance by OHSD to the office chiefs. The Deputy Director's Office provided oversight and support.

The Rhode Island Department of Health reported experiencing no problems in completing the survey. Respondents felt that the guidelines were clear, with definitions broad enough to allow categorization of personal health care services according to survey categories. Some problems were encountered in breaking down broad health department services into the detailed service categories of the survey instrument. End-of-year expenditures were used to complete the exercise; these data are considered to be very reliable.

Table 8. Rhode Island Personal Health Care Services, By Service Group and Delivery Method (by percent of total spending in the service group)

Group	Public MCO	Health Department Comprehensive Clinic Capitated	Health Department Comprehensive Clinic Non-Capitated	Heatth Department Categorical Clinic	Contracted Capitated	Contracted Non-Capitated	Total
Comprehensive Personal Health Services	-						
Comprehensive Primary Care Services	-						-
Primary Medical Services	-			5.4	-	94.6	100.0
Specialty Health Services	-					100.0	100.0
Other Professional Health Services	-			0.7	-	99.3	100.0
Inpatient Services							100.0
Enabling Services						100.0	100.0

One suggestion for improving the methodology involved piggybacking this survey with the Public Health Expenditure Project, given that completion of the survey was time consuming in an era of scarce resources. Potential uses of this type of data include constituency building and budget negotiations.

Arizona Department of Health Services

Summary of Site Visit, **July 15-16. 1996**

A site visit to one of the survey participants was conducted to help project staff better understand the problems and general experiences of implementing the survey. The Arizona Department of Health Services (ADHS) was chosen for the following reasons:

- All LHDs in Arizona were asked to test the instrument and the range of their responses was instructive;
- Arizona is a state in which a mix of service delivery methods are used, ranging from direct health department service delivery provision to health departments serving as managed care entities; and
- Two county health departments in Arizona have established managed care entities that are awarded health care service delivery contracts for Medicaid beneficiaries through the Arizona Health Care Cost Containment System.

A schedule of visits and an interview protocol can be found in Appendix III.

Prior to the site visit, PHF received results from the Arizona personal health care expenditure survey. Arizona's submission included a disaggregated collection of results from specific divisions and a few local health departments that had attempted the exercise. Some of the submissions were incomplete. Accompanying the results was a fairly critical evaluation of the tool that spelled out reasons for respondents' frustration with the survey and why complete, statewide data could not be obtained in Arizona. Some of the reasons cited include:

- Concern that the intense focus on only one of the ten essential public health services, and particularly this one, could misconstrue the full mission of public health departments.
- The delay between the completion of the Public Health Expenditures Project in June 1995 and the implementation of this survey in April 1996.
- Numerous competing requests to ADHS for data, among which were the Public Health Expenditures Project and this complementary personal health care expenditure survey.
- ADHS accounting systems are not consistent with the categories of expenditures sought on the survey.
- Over-burdened staff from several units were not willing to devote time to a project for which the value was not readily apparent.
- Failure of survey instructions to provide clear guidance on how to report funding allocated by ADHS in ways not consistent with tool categories.
- As a mix of expenditure and budget data were reported by the various Arizona respondents, ADHS questioned the reliability of estimates that could be produced from its data, much less in the reliability of estimates aggregated across other states and localities that also likely used varying methods.

Because of the fragmentation of its data submissions, ADHS's data could not be included in the overall analysis of the five pilot sites. However, ADHS staff committed extensive effort to evaluating the tool and hosting the site visit and provided valuable suggestions that can be applied to future iterations of the survey. Among these are:

Leadership is key. Given a reasonable resistance to work for which the value and utility is unclear, national studies must be responsive to the issues of those in the front lines in order to ensure the success of new projects. Federal officials must recognize the knowledge and experience of state and local health officials and *vice versa.* All must be flexible in the design and testing of new approaches.

Initial technical assistance is critical. Because the survey categories do not closely match health department spending categories, managers are required to apportion broad categorical services into the more detailed survey categories. An initial meeting with program and finance staff to agree on decision rules would improve consistency and reliability of results.

Participation of project staff at this initial stage would also contribute to a better understanding of the tool and to improved consistency between state/local health departments.

Minimize additional respondent burden. Even if the usefulness of the survey were well established, every effort should be made to ensure that additional work is minimized. A variety of approaches are available, including:

- Transitioning federal funding of health departments from categorical grants to **a more** consolidated, functional framework such as the ten essential public health services.
- Combining the Pubic Health Expenditure Project and this complementary personal health care survey.
- Reducing the personal health care services to only the broad categories (comprehensive personal health care services, primary medical services, enabling services, etc.), eliminating detailed services within each broad category.

Example of Expenditure Results - Division of Behavioral Health Services

Although data from Arizona were not in the cross-site analysis presented earlier, ADHS Division of Behavioral Health Services (DBHS) was the one segment of the agency most willing to participate, committing extensive time and effort to providing complete data. A profile of DBHS expenditures is provided below.

Overview

DBHS spent a total of $246.6 million in FY '95 for personal health care services. All personal health care services were contracted out, both on a capitated (33 percent) and on a non-capitated (67 percent) basis. No bundled services were offered. Expenditures included those reported by the Arizona State Hospital.

The service group Other Professional Services accounted for the largest proportion (51 percent) of total DBHS expenditures. In-patient Services and Enabling Services (spent mainly on case management) each accounted for 24 percent of total expenditures.

Expenditures by Service Group

No services offered by DBHS were provided as a package of comprehensive services; all were delivered as discrete services. Table 9 shows the distribution of expenditures by group of services.

Within the Primary Medical Services group, the only expenditures were for HIV early intervention and treatment ($0.8 million) and diagnostic laboratory and X-ray services ($40,412). Psychiatry accounted for the largest expenditures ($0.8 million) in the Specialty Health Services group. Mental health treatment/counseling accounted for $85.3 million of Other Professional Health Service expenditures, followed by substance abuse treatment/counseling with $21 .O million. DBHS administrative expenses and a Court Monitor added a further $1 .O million. The largest expenditure in the Enabling Services group was for case management ($52.4 million), followed by outreach ($2.1 million) and housing assistance

($2.0 million). “Vocational/Rehabilitation Club House” was added as a category to this group, contributing $1.8 million.

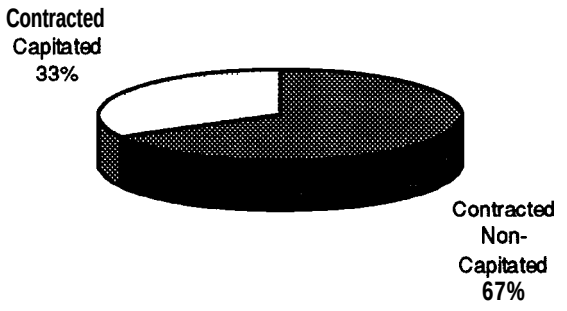
Table 9. Arizona Division of Behavioral Health Services Expenditures by Service Group

Service Group	Expenditures (000s)	Percent
Comprehensive Personal Health Care Services		
Comprehensive Primary Care Services	-	
Primary Medical Services	$842	0.3
Specialty Health Services	1,016	0.4
Other Professional Health Services	126,049	51.1
Inpatient Services	59,678	24.2
Enabling Services	59,049	23.9
TOTAL	$246,635	100.0

Expenditures by Delivery Method

DBHS assured the provision of all its services through contracts with other providers, either on a capitated (33 percent) or fee-for-service (67 percent) basis. Figure 7 displays expenditures by delivery methods.

Figure 7
Arizona Division of
Behavioral Health Services
Expenditures by Delivery Method



Total: $246.6 million

Service Groups by Delivery Methods

All Primary Medical Services are provided as contracted, non-capitated services. Distribution of expenditures for services by delivery method are displayed in Table 10.

Table 10. Arizona Division of Behavioral Health Services, By Service Group and Delivery Method (by percent of total spending in the service group)

Group	Public MCO	Health Department Comprehensive Clinic		Health Department Categorical Clinic	Contracted		Total
		Capitated	Non-Capitated		Capitated	Non-Capitated	
Comprehensive Personal Health Services							
Comprehensive Primary Care Services	-						
Primary Medical Services				-		100.0	100.0
Specialty Health Services					18.7	81.3	100.0
Other Professional Health Services	-		-		24.9	75.1	100.0
Inpatient Services					48.4	51.6	100.0
Enabling Services					35.2	64.8	100.0

Evaluation of Survey Instrument and Guidelines

The process involved financial/budget staff from both the Arizona Department of Health Services' main budget office and the Division of Behavioral Health Services. A spreadsheet was developed which apportioned total dollars by DBHS program to the appropriate service on the survey instrument. Approximately 38 hours were required to complete the exercise. Actual FY '95 expenditure data were used, contributing to the reliability of the estimates.

Respondents felt that the survey instrument was well designed and instructions were clear but that there was a bias toward medical data. Arizona's behavioral health system offers a broad continuum of services within a statewide managed care structure that are supported by community-based agencies. This is a significant difference from the institutional, medical orientation that the survey was perceived to capture. DBHS was, however, able to address the needs of the mental health program expenditures within the framework of the survey instrument.

The timing of the survey-late May-was particularly inopportune, given the focus on end-of-year preparations and the contracting process at that time.

VI. LESSONS LEARNED AND SUGGESTIONS FOR THE FUTURE

This project involved a pilot test of a methodology to collect personal health care expenditures in state and local health departments. Key lessons were learned involving the design and implementation of the methodology. These lessons are summarized in the discussion that follows.

Suggestions for Improving the Methodology

Provide strong leadership in the initial implementation stages. Given the complementary nature of this survey to the Public Health Expenditure Survey, strong and consistent support must be voiced for use of the essential public health services taxonomy as an organizing framework for public health. When that happens, leaders at federal, state, and local levels must then demonstrate commitment to and expect quality results from application of both the essential public health services and the complementary personal health care expenditures methodologies.

Minimize additional respondent burden. Respondents' commitment to survey implementation is closely correlated with respondent burden and has a direct impact on the quality of results. The personal health care services expenditure survey requires staff to partition categorical expenditures to a different framework that allows for comparisons over time and across levels of government. In an effort to keep additional work to a minimum, the personal health care services expenditure survey should be combined with the Public Health Expenditures tool. This would alleviate the disconnect between the two surveys that occurred during this pilot and would improve the consistency of estimates between the two instruments. In addition, the level of detail demanded by the survey instrument may not be necessary; consideration should be given to reducing both the number of service categories to the broad service groups and the number of service delivery methods included in the survey instrument. Improved respondent commitment might, in turn, improve feedback on decision rules applied during survey implementation. Knowledge of these decision rules would contribute to a more consistent interpretation of results and could eventually improve survey instructions.

Improve respondent perceptions of the usefulness of the survey. Respondents' commitment to survey implementation also directly results from perceptions of usefulness of the results. The utility of collecting expenditure data lies mainly in the program and policy questions which the data raise or attempt to answer. Discussion of potential uses of survey results as part of introducing the methodology to respondents would contribute to a better understanding and increased commitment on the part of respondents. Potential uses include:

- **Provide a basis for policy discussions** regarding the relationship between actual need and existing investments in services, and the appropriate niche for the health department in the changed health care environment.

- **Assess the impact of changes** in the delivery system by providing a consistent method for tracking changing roles over time.

- **Enable states to compare** their efforts with those of other states.

- **Highlight major funding shifts** to serve as an early warning for health department managers of adverse impacts on the health department of major policy initiatives.

Expenditures within a given year can be examined to determine if there is a pattern in the way certain services are being provided, between years to see changes over time, or between states/localities. These patterns might indicate differences, for example, in services or in delivery methods between state and local health departments or between rural and urban states. Further investigation might reveal contributing factors which help explain these differences. Where differences cannot be explained in this way, health departments might begin asking why similar health departments provide services differently and if they are achieving more efficient or effective delivery of services. This might eventually lead to establishing guidelines or benchmarks for delivering efficient and effective personal health care services.

To carry the example further, health departments could then examine the appropriateness of changing the mix of delivery mechanisms for personal health care services within the prevailing sociopolitical climate. Where services were contracted out or privatized, the role of the health department and the funding mix with regard to those services could be further examined.

Within a health department, a useful next step in the analysis of these personal health care expenditures would be to place these expenditures within the context of existing demographic, socioeconomic, and health status variables to determine the degree to which service delivery is meeting actual need.

Experiment further with mechanisms to collect local health department data. As with the Essential Public Health Expenditures Project, this survey suffered from limited access to local health department data. Discussions should continue with organizations, including the National Association of County and City Health Officials (NACCHO) and the National Association of Local Boards of Health (NALBOH) to develop a mechanism for working with multiple local health departments and to include the essential public health services taxonomy in their member reporting. The follow-up study currently underway with PHF, NACCHO, and NALBOH examining methods at the local level for collecting essential public health expenditures would be a good opportunity to refine this methodology.

Further refine survey methodology. Even if the number of categories and/or delivery methods in the survey instrument were reduced as suggested above, further refinements would still be required to address difficulties experienced by participants in using the survey instrument and methodology. Some preliminary suggestions include:

- Eliminate overlaps between definitions and provide improved decision rules to guide survey completion.

- Ensure that respondents use expenditure data, not budget information.

- Ensure that program staff work with finance staff in survey completion.

- Provide technical assistance to respondents, especially during the initial stage of survey completion.

- Based on the time taken to complete the survey (eight weeks to four months), review the timeframe to ensure that it is appropriate to the task and that results can be released in a timely manner.

- Review service delivery mechanisms to ensure that they reflect current delivery mechanisms in the rapidly changing health care environment.

Conclusion

The study results evidence a wide diversity in health department roles and personal health care services offered, reflecting the needs of each community. The methodology, built on health department officials' own inputs, offers a standard format for collecting health department personal health care expenditures. By establishing a baseline which allows for trend analysis of expenditures over time, health department officials could have more information for establishing their own priorities, monitoring trends in a changing health care environment, and taking appropriate corrective actions in a timely manner. Once the levels of funding and the nature of doing business are tracked in a consistent manner, managers and policy makers can use this information to ask further important questions regarding performance and priorities.

Strong and committed leadership must be provided to ensure quality implementation of any new methodology. This commitment can then lead to serious consideration of participants' experience in implementing the personal health care expenditure survey and to improvements in a survey tool which ultimately can provide critical information for improving public health personal health care services.

APPENDICES

APPENDIX I

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

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APPENDIX I

PART 1

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES PROJECT OVERVIEW

Background

As the states engage in health care reform efforts, the future role of state and local health departments in delivering, as well as in monitoring access to personal health services, is being debated. The Joint Council of Official Public Health Agencies organized an initiative to provide an opportunity for representatives of public health agencies to discuss strategies for the future of public health in the midst of this changing public-private environment. Joint Council workgroups reviewed the different dimensions of adaptation to change, including the range of options open to health departments from direct service delivery through public health facilities to a variety of supportive and monitoring functions vis **à** vis the private delivery system. Concomitantly, the Joint Council's Data Systems Workgroup examined the information infrastructure and data elements needed to support the evolving public health role in the reformed delivery system.

The Public Health Foundation (PHF) is assisting the Health Resources and Services Administration in developing a categorization schema for reporting comparable information on state and local health agency personal health services. Over the years, a number of Federal and other efforts have collected data on responsibilities and expenditures for personal health services traditionally provided by state and local health agencies. Looking forward to potentially reformed delivery systems that may significantly alter the way in which public health agencies provide services, policy makers, managers and researchers need to be able to assess the impact of changes in the delivery system.

A recently completed pilot project of the U.S. Public Health Service-Public Health Expenditures Project-developed tools to measure expenditures on the essential public health services at the state and local levels. Based on a draft report currently being reviewed by the participating states, it is evident from preliminary analysis of this data that a large portion (35%) of state and local health department expenditures focus on personal health care services. With states rapidly moving toward managed care, it is important that state and federal officials have access to reliable data to track the impact of changing expenditure patterns on the ability of health departments to ensure the provision of personal health care services and the other essential public health services. This effort is being closely coordinated with the Public Health Expenditures Project, representing a further delineation of the public health expenditures tool by measuring state and local capacity to carry out the essential service "link people to needed personal health services and assure the provision of care when otherwise unavailable." It will also feed into a larger public health data infrastructure project, also funded by PHS, which aims to build on existing health data systems to create **an** on-going national public health information framework.

Goals and Objectives

The overall goal of this project is to develop a methodology to collect consistent and complete data on state and local health agency personal health care services to enable policy makers, managers and researchers to assess the impact of changes in the health care delivery system.

APPENDIX I

PART 1

Objectives include:

- Develop categories of personal health services which are sensitive to policy questions under health care reform, taking into account local, state and federal perspectives;
- Determine the extent to which consistent and complete information can be collected across states using agreed upon common definitions;
- Document the nature of the information sources and the processes for extracting data at the state level; and
- Assess the potential for and level of investment required to obtain data from public health agencies below the state level.

Uses of **the Data**

The data collection instrument has been designed as a matrix to capture information on the extent to which traditional public health personal health care services are being bundled into comprehensive services, shifts among personal health service spending categories, and shifts in the way health departments are delivering those services. Current health care structures across states present a wide spectrum of health care delivery mechanisms, ranging from traditional categorical services through health department-run clinics, to a mix of traditional delivery and managed care (e.g. Austin, Texas), to sole managed care delivery (e.g. Denver, Colorado and Muitnomah County, Oregon). This instrument will assist health departments in documenting their movement along this spectrum of delivery mechanisms.

Results will help health department managers document the impact on the health department of major policy initiatives, such as moving Medicaid beneficiaries into managed care, and will enable states to compare their efforts with those of other states. It will also help them better understand how their efforts to reorganize functionally are affecting their ability to deliver personal health care services and will give them a consistent method for tracking their changing roles over time.

APPENDIX I

PART 2

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

INSTRUCTIONS

1. This packet requests information on your agency's expenditures for personal health care services. Please read all of the enclosed materials before starting the exercise.

2. Report total fiscal year '95 **expenditures** of your health department for personal health services on the Total Personal Health Services line at the bottom of the Survey Protocol. See Attachment A - Definition of Expenditures for assistance in deciding which expenditures to include and which to exclude from the data collection exercise. If it is not possible to report actual expenditures, report budget figures and provide in Section C, Item 4 - Evaluation of Data Collection Instrument, an explanation of why expenditures could not be reported.

   Please indicate the timing of your fiscal year, e.g. July-June at the top of Page 1 of the survey protocol.

3. Provide actual expenditures for the specific personal health care services in Column 2, rows 1 - 44. Refer to Attachment B -Service Definitions. Rows 1 through 44 should sum to the Total Personal Health Services line at the bottom of the form.

4. Apportion personal health care services expenditures in Column 2 according to delivery method (columns 3-8) by percentage of total expenditure (row should sum to 100 percent). (See Attachment C for Delivery Method Definitions.)

5. Administrative expenses supporting specific personal health services, including client-based data systems, should be included under those services. Exclude general administrative expenses of the health department that support all health department functions and programs.

6. If your agency participated in the U.S. Public Health Service effort to collect expenditures for essential public health services (Public Health Expenditures Project), you should determine the relationship between expenditures provided for that survey and those provided for this study. Theoretically, total expenditures reported for this survey should approximate and delineate the amount reported under Item #6 (both a and b) of the Public Health Expenditures Project. If there is a deviation, please explain under Section C of the Evaluation (Item 4).

7. The timeline for data collection is approximately eight (8) weeks, with a due date to the Public Health Foundation of May 24, 1996.

If you have any questions about use of the packet or instructions, please contact Kay Eilbert or Mike Barry of PHF, 1220 L Street, NW, Suite 350, Washington, D.C. 20005, Phone (202)898-5600, Fax (202)898-5609, email: 72054,1215@compuserve.com.

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

DEFINITION OF EXPENDITURES

State and local health agencies are asked to report their expenditures for personal health services. For the purpose of this reporting packet, expenditures are defined as:

> "Funds from a variety of sources spent, obligated, and encumbered from the agency's operating budget for a 12-month fiscal year."

Reported expenditures should **include:**	Reported expenditures should **exclude:**
• Encumbrances or obligations to be paid with the reporting period's monies. • Amounts for equipment items expended from the agency's operating budget, unless otherwise classified as a capital expenditure for the state. • All fee income expended for programs. • Agency administrative portions of state and federal facilities construction grants that are considered to be federal pass-through transactions, rather than agency expenditures.	• Expenditures of the state Medicaid agency. • Amounts spent by other agencies that supplied direct assistance (e.g., personnel, services, goods, and facilities) in lieu of cash to the agencies for which expenditures are being reported. • Expenditures not in the operating budget such as new buildings with original equipment. These expenditures are normally made from special capital accounts. • Fee income collected but not retained and expended by the agencies. • Adjustments to the operating budget such as reimbursements for expenditures from the previous **fiscal** year (i.e., negative expenditures for the current fiscal year).

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

SERVICE DEFINITIONS

Service	Definition	Does not include:
Comprehensive Personal Health Services		
1. Comprehensive personal health services	A bundled package of personal services that includes both primary care and specialty services delivered on an inpatient or outpatient basis.	Primary Medical Services (delivered as a comprehensive package of services or as discrete services (Services 2-44)
Comprehensive Primary Care Services (delivered as other than a comprehensive package of personal health services - item 1)		
2. Comprehensive primary care services	The bundled package of primary care services generally provided by general internists, family practitioners, generalist pediatricians and related mid-level providers. In the context of managed care these would be the services for which a primary care case manager physician would be responsible	Specialty and inpatient referrals or discrete primary medical services (delivered as other than a comprehensive package of services)(Services 1, 3-44)
Primary Medical Services (delivered as other than a comprehensive package of services)		
3. Diagnostic aboratory and X-ray procedures (technical component)	Technical component of laboratory and diagnostic X-ray procedures as part of primary medical care to individuals.	Services of a physician to order or to analyze/interpret results from these procedures. (Service 4)
4. Diagnostic tests/screenings (professional component)	Professional services to order and analyze/interpret results from diagnostic tests and screenings as part of primary medical care to individuals.	Diagnostic procedures (Service 3)
5. Urgent/emergency medical care	Medical care provided on a non-scheduled basis to treat urgent and emergency conditions.	
6. Family planning (contraceptive management)	Provision of contraceptive/birth control or infertility treatment. counseling and education by providers.	Family planning when part of Ob/Gyn care (Service 13). Separate counseling and education provided by other staff (Service 35)
7. HIV - early intervention and treatment	Purchase and provision of AZT/other drugs. CD-4 counts,and individual counseling.	HIV treatment when part of Ob/Gyn treatment (Service 13)
8. Immunizations	Provision of preventive vaccines.	Immunization as part of outbreak control.
9. Prenatal care	Pregnancy testing. antepartum fetal assessment. periodic visits for healthcare services to pregnant women and adolescents:ntended to improve pregnancy outcomes	Specialized services: ultrasound. genetic counseling and testing. amniocentesis (Service 13)
10 Pediatric clinic	EFSDT. well baby care. diagnosis and treatment. referral and tracking. outreach, consumer education and case management provided to children.	Immunization and specialized services (Service 8)

Service	Definition	Does not include:
11. School health	Primary care, immunizations. health and nutrition education pregnancy preventron pregnancy testing. prenatal care or referral counseling	Any care provided outside school-based clinic
12 Other (List)	(Define)	
13 Other (List)	(Define)	
Specialty Health Services (**delivered** as other than a comprehensive package of services - item 1)		
14 OB/Gyn care	Services provided by a nurse. nurse practitioner. nurse midwife or physician. Including annual pelvic exams and pap smears. follow-up of abnormal findings. contraception and diagnosis and treatment of sexually transmitted diseases. including HIV Provision of ultrasound, genetic counseling and testing. amniocentesis. labor and delivery professional care. and postpartum care.	Primary prenatal care (Service 9)
15 Genetic services	Newborn screening. case management. birth defect surveillance and follow-up. AFP and other non-invasive testing. professional and lay education. carrier screening. genetic counseling (e.g through outreach. subsidies to university teaching hospitals)	
16. Children's rehabilitation services	Healthcare services for children wrth special needs. e g occupational. physical. speech and recreational therapy	
17 STD clinics	Counseling. condom distribution, testing, diagnosis and treatment and partner notification	STD set-vices when part of Ob/Gyn treatment (Service 13)
18. Other specalty medical care	Includes services provided for TB therapy, lead poisoning treatments, diabetes clinics, cardiac care clinics. etc or services provided by medical professionals trained in any of the following specialty areas: Allergy. Anesthesiology: Dermatology: Gastroenterology. General Surgery. Neurology: Podiatry; Radiology: Psychiatry: Anesthesiology.	
19. Other (List)	(Define)	
Other Professional Health **Services**		
20 Dental care	Provision by a dentist or dental hygienist of preventive. restorative. or emergency services Preventive dental care includes cleaning. prophylaxis. sealants. and fluoride treatments.	
21. Home health services	Nursing care, homehealth aide services. medical supplies, equipment and appliances, physical and occupational therapy. speech pathology and audiology services provided to individuals in a home setting	Homemaker respite services

Service	Definition	Does not include:
22. Substance abuse treatmenffcounseling	Includes treatment for abuse of alcohol and/or other drugs. Counseling and/or psychosocial treatment services provided to individuals with substance abuse problems. May include screening and diagnosis, detoxification, individual and group counseling, self-help support groups, alcohol and drug education, rehabilitation, remedial education and vocational training services, and aftercare.	School campaigns such "So No to Drugs Day" or other community-wide substance abuse prevention.
23. Mental Health treatmenffcounseling	Mental health therapy, counseling or other treatment provided by a mental health professional including 24-hour crisis intervention/counseling	
24. Nutrition services	Screening, education, counseling and direct food services	
25 Occupational, physical, or speech therapy	Assistance designed to improve or maintain an individual's employment skills, physical capabilities, or speech.	Those services provided under children's rehabilitation services (Service 15)
26. Pharmacy	Dispensing of prescription drugs and other pharmaceutical products.	Those drugs already attributed to specific services. e.g. HIV (Service 7)
27. Other (List)	(Define)	
28. Other (List)	(Define)	
Inpatient Services		
29. In-patient services	All services which require overnight(s) in a health care facility.	In-patient services provided under ob/gyn care (13), children's rehabilitation services (15) and other specialty care (17).
Enabling Services		
30. Case management	Client-centered service that links clients with health care and psychosocial services to insure timely, coordinated access to medically appropriate levels of health and support services and continuity of care. Key activities include: 1) assessment of the client's needs and personal support systems; 2) development of a comprehensive, individualized service plan; 3) coordination of services required to implement the plan; client monitoring to assess the efficacy of the plan; and 4) periodic reevaluation and adaptation of the plan as necessary. Includes risk assessment, eligibility assistance, coordination and referral, follow-up and tracking, and documentation.	
31. Child care	Assistance in caring for a user's young children during medical and other health care visits.	
32. Discharge planning	Case management-type services related to an individual's discharge from the hospital.	

Service	Definition	*Does not include:
33. Eligibility assistance	Assistance in securing access to available health, social service and other assistance programs, including Medicaid, WIC, SSI, Food stamps, AFDC, and related assistance programs. Includes outstationed eligibility workers.	
34. Employment/educational counseling	Counseling services to assist an individual in defining career/employment/educational interests, and in identifying employment opportunities and/or education options.	
35. Food bank/delivered meals	Provision of actual food or meals.	Finances to purchase food or meals
36. Health education	Client-based personal assistance provided to promote knowledge regarding health and healthy behaviors, including knowledge concerning sexually transmitted diseases, prevention of fetal alcohol syndrome, smoking cessation, reduction in misuse of alcohol and drugs, improvement in physical fitness, control of stress, nutrition, and other risk factors.	
37. Homemaker/aide assistance	Non-medical, non-nursing assistance with household chores and/or activities of daily living.	
36. Housing assistance	Assistance in locating and obtaining suitable shelter, either temporary or permanent. May include locating costs, moving costs, and/or rent subsidies.	
39. Interpretation/translation services	Services to assist individuals with language/communication barriers in obtaining and understanding needed services.	
40. Nursing home and assisted-living placement	Assistance in locating and obtaining nursing home and assisted-living placements.	
41. Outreach	Case finding, education or other services to identify potential clients and/or facilitate access/referral of clients to available services, including information and referral hotlines.	
42 Transportation	Transportation provided or made available by the health department for clients to enable them to access needed primary care or specialty services.	
43. Development of primary care services in underserved communities	G rants for primary care services in underserved communities	
44. Other (List)	(Define)	
45. Other (List)	(Define)	

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

DELIVERY METHOD DEFINITIONS

Health departments fulfill their role as personal care providers by directly providing services with their own personnel at their own sites or contracting out to other providers in the community to deliver the care. The following categorization is an attempt to depict a continuum from health departments operating their own HMOs (column 3), to health departments providing discrete services in order to address community health problems (column 6). When the health departments do not deliver care directly, they may use contractors either on a capitated or individual service basis (columns 7 and 8). The dimension we are trying to capture is the delivery mode not the financing mechanism, although financing often affects structure.

Health Departments that provide personal care

Public Managed Care Organization (column 3)

The health department owns and operates an HMO independently or with another entity such as a university hospital, e.g., Multnomah County in Oregon.

Health Department-run Comprehensive Clinics (capitated) (column 4)

The health department operates comprehensive clinics, e.g., provide a wide range of services, which serve as gatekeepers under contract with a larger HMO plan for some or all patients, e.g., Kentucky.

Health Department-run Comprehensive Clinics (non-capitated) (column 5)

The health department operates comprehensive clinics that serve patients on a fee-for-service basis, e.g., the LHD is not responsible for total primary care services for enrolled members, e.g., Cincinnati, where there is a linked system of community health centers providing comprehensive care.

Health Department-run Categorical Clinics or Services (column 6)

Targeted public health clinics providing specialized care, e.g., hypertension clinics, diabetes clinics, etc.

Health Departments that contract with community providers to provide personal care

Capitated Arrangements (column 7)

The health department pays a capitated amount (set rate per member) to the contractor, e.g., pays a university hospital for all pediatric cardiac care services, or pays an HMO to act as primary care gatekeeper for indigent patients ineligible for Medicaid.

Non-capitated Arrangements (column 8)

The health department pays for specific services as they are provided by an outside contractor.

Service	Definition
3. Eligibility assistance	Assistance in securing access to available health, social service and other assistance programs, including Medicaid, WIC, SSI, Food stamps, AFDC, and related assistance programs. Includes outstationed eligibility workers.
14. Employment/educational counseling	Counseling services to assist an individual in defining career/employment/educational interests, and in identifying employment opportunities and/or education options.
35. Food bank/delivered meals	Provision of actual food or meals.
36. Health education	Client-based personal assistance provided to promote knowledge regarding health and healthy behaviors, including knowledge concerning sexually transmitted diseases, prevention of fetal alcohol syndrome, smoking cessation, reduction in misuse of alcohol and drugs, improvement in physical fitness, control of stress, nutrition, and other risk factors.
37. Homemaker/aide assistance	Non-medical, non-nursing assistance with household chores and/or activities of da living.
38. Housing assistance	Assistance in locating and obtaining suitable shelter, either temporary or permane May include locating costs, moving costs, and/or rent subsidies.
39. Interpretation/translation services	Services to assist individuals with language/communication barriers in obtaining a understanding needed services.
40. Nursing home and assisted-living placement	Assistance in locating and obtaining nursing home and assisted-living placements.
41. Outreach	Case finding, education or other services to identify potential clients and/or facilita access/referral of clients to available services, including information and referral hotlines.
42 Transportation	Transportation provided or made available by the health department for clients to enable them to access needed primary care or specialty services.
43. Development of primary care services in underserved communities	G rants for primary care services in underserved communities
44. Other (List)	(Define)
45. Other (List)	(Define)

APPENDIX I

PART 3

FY ______, ENDING ______

8A PUBLIC HEALTH AGENCIES

	Contracted Services	
Health Department-run Categorical Clinics % (6)	Capitated % (7)	Non-capitated % (8)

(columns 3-8 should add to 100% of column 2)

OFFICAL NAME OF AGENCY _____ **FY** _____, **ENDING** _____

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

SURVEY PROTOCOL

		Delivery Method (enter percentages only - columns 3-8 should add to 100% of column 2)					
			Health Dept.-run Comprehensive Clinics			Contracted Services	
Scope of Services (1)	Health Department Expenditures $000 (2)	Public Managed Care Organization % (3)	Capitated % (4)	Non-capitated % (5)	Health Department-run Categorical Clinics % (6)	Capitated % (7)	Non-capitated % (8)
Comprehensive Personal Health Services							
1. Comprehensive personal health services (attach description of services)							
Comprehensive Primary Care Services (*delivered as other than a comprehensive package of personal health services*)							
2. Comprehensive primary care (attach description of services)							
Primary Medical Services (*delivered as other than a comprehensive package of services*)							
3. Diagnostic laboratory and x-ray (technical component)							
4. Diagnostic tests/screenings (professional component)							
5. Urgent/emergent medical care							
6. Family planning services (contraceptive management)							
7. HIV - early intervention & treatment							
6. Immunizations (not outbreak control)							
9. Prenatal care							
10. Pediatric clinic							

PART 3

SURVEY PROTOCOL

		Delivery Method (enter percentages only - columns 3-8 should add to 100% of column 2)					
			Health Dept.-run Comprehensive Clinics			Contracted Services	
Scope of Services (1)	Health Department Expenditures $000 (2)	Public Managed Care Organization % (3)	Capitated % (4)	Nontapltated % (5)	Health Department-run Categorical Clinics % (6)	Capitated % (7)	Non-capitated % (8)
11. School health							
12. Other - list							
13. Other - list							
Specialty Health Services (delivered as other *than a comprehensive package of services)*							
14. **OB/GYN** care							
15. Genetic services							
16. Children's rehabilitation services							
17. **STD** clinics							
18. Other specialty medical care							
19. Other - list							
Other Professional Health Services (delivered *as other than a comprehensive package of service)*							
20. Dental care							
21. Home health services							
22. Substance abuse treatment/counseling							
23. Mental health treatment/counseling							
24. Nutrition services							

PART 3

SURVEY PROTOCOL

		Delivery Method (enter percentages only - columns 3-8 should add to 100% of column 2)					
			Health Dept.-run Comprehensive Clinics			Contracted Services	
Scope of Services (1)	Health Department Expenditures $000 (2)	Public Managed Care Organization % (3)	Capitated % (4)	Non-capitated % (5)	Health Department-run Categorical Clinics % (6)	Capitated % (7)	Non-capitated % (8)
25. Occupational. physical or speech therapy							
26. Pharmacy							
27. Other - list							
28. Other - list							
In-patient Services							
29. In-patient services							
Enabling Services							
30. Case management (client-based)							
31. Child care							
32. Discharge planning							
33. Eligibility assistance							
34. Employment/educational counseling							
35. Food bank/delivered meals							
36. Health education (client-based)							
37. Homemaker/aide assistance							
38. Housing assistance							

PART 3

SURVEY PROTOCOL

		Delivery Method (enter percentages only - columns 3-8 should add to 100% of column 2)					
			Health Dept.-run Comprehensive Clinics			Contracted Services	
Scope of Services (1)	Health Department Expenditures $000 (2)	Public Managed Care Organization % (3)	Capltated % (4)	Nontapltated % (5)	Health Department-run Categorical Clinics % (6)	Capitated % (7)	Non-capiteted % (8)
39. Interpretation/translation services							
40. Nursing home and assisted-living placement							
41 Outreach							
42. Transportation							
43. Development of primary care services in underserved communities							
44. Other - list							
45. Other - list							
Total Personal Health Services (sum of lines 144)							

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

EVALUATION OF DATA COLLECTION INSTRUMENT

Please use this form to provide an evaluation of the overall data collection effort. Specifically, we ask that you comment on the following:

A. **The process you used to collect the data:** Who did you involve within your agency in the data collection and how did you organize and coordinate that process? What is the estimated level of resources (e.g., staff hours and/or dollars) your agency invested in the process?

B. **The design of the data collection instrument:** How user-friendly is the instrument? How clear were the instructions, definitions and forms? Do you feel the instructions (Item 2) were comprehensive and specific enough to help you identify and categorize all of your agency's personal health expenditures in a reasonable way? Feel free to comment directly on the forms and return them to PHF.

C. **Sources of information and reliability of estimates:** What unique sources did you tap for the data collection effort (e.g., internal program budgets, time allocation sheets, Medicaid billing information, etc.)? How comfortable do you feel with the estimates you provided? Describe what you feel to be the strengths and limitations of the information you reported.

D. **Overall evaluation of process and its value to your agency:** How would you evaluate the overall data collection effort? What do you feel worked well and did not work well? How did (or could) the process and resulting information help your organization? What would you change to make it more helpful? Provide general comments on the internal process used by your agency as well as on PHF's and HRSA's role in leading and assisting in this effort.

We also welcome any additional information about issues in your state that may be of interest or of help to us in understanding the data you provided (e.g., the organizational make-up of public health responsibilities in your state, new and emerging technologies being employed in your state, or the changing roles and relationships among public health agencies and managed care organizations in your state).

A. Process

B. Instrument Design

C. Sources/Reliability

D. Overall Evaluation

APPENDIX II

PARTICIPANT LIST
PERSONAL HEALTH CARE SERVICES WORKGROUP
PUBLIC HEALTH EXPENDITURES WORKSHOP
JUNE 29, 1995

Terry Bleier
Texas Department of Health
Washington, D.C.

Joanne Bennison
New York State Association of
County Health Officials
Albany, New York

Sharon Bragg
Iowa Department of Public Health
Des Moines, Iowa

Tom Fronk
Multnomah County Health Department
Portland, Oregon

Patricia Kimmel
Illinois Department of Public Health
Springfield, Illinois

Merrill Krenitz
Arizona Department of Health Services
Phoenix, Arizona

Deborah Laufer, Facilitator
Rhode Island Department of Health
Providence, Rhode Island

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New York City, New York

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Rockville, Maryland

Sue Madden
Public Health Foundation
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Sharon McKenna
Louisiana Department of Health
and Hospitals
New Orleans, Louisiana

Lou Mahoney
Health Resources and Services
Administration
Rockville, Maryland

Sue P. Milam
City of Austin Health Department
Austin, Texas

Michael Millman
Health Resources and Services
Administration
Washington, D.C.

Lucia Miltenberger
Washington State Department of Health
Olympia, Washington

Nancy Rawding
National Association of County and City
Health Officials
Washington, D.C.

Peter Van Dyck
Bureau of Maternal and Child Health
Rockville, Maryland

Beverly Weaver
City of Dallas Health Department
Dallas, Texas

Lori Whitehand
Public Health Foundation
Washington, D.C.

ARIZONA SITE VISIT
JULY 15-16, 1996
SCHEDULE OF VISITS

MONDAY, July 15, 1996

9:00	Dr. Jack Dillenberg, ADHS Director Dr. Larry Platt, Assistant Director, Division of Public Health Services Doug Hirano, Executive Assistant
9:30	Doug Hirano, Special Assistant Karen Pitico, Student Intern, Arizona Graduate Program of Public Health
10:30	Jane Pearson, Chief, Bureau of Community & Family Health Services
1:30	Dr. Steve Englender, Director, Maricopa County Department of Health
3:00	Christopher Brown, Chief, Office of HIV/STD Services

TUESDAY, JULY 16, 1996

9:30	Michael Prudence, ADHS Chief Financial Officer Michael Kearns, ADHS Chief Budget Officer
10:00	Phil Lopes, Chief, Bureau of Health Systems Development
11 :00	Juman Abujbara, MD, MPH, Chief, Office of Acute Care Services, Arizona Health Care Cost Containment System
1 :00	Anne Urban, Chief, Office of Chronic Disease Prevention

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

SITE VISIT PROTOCOL - ARIZONA
JULY 15-16, 1996

Overall Goal/Objectives of Project

The U.S. health care system is undergoing enormous change, with a view mainly to cost containment and expanded access for vulnerable populations. In 1993, in the midst of national health care reform debate, public health practitioners became concerned that public health programs' ability to protect the nation's health may be affected by these rapid changes in the health care environment. While national reform did not succeed, states have moved into the gap. In order to inform policy decisions and begin to monitor the effect these changes are having on the public health infrastructure, baseline estimates of expenditures for essential public health services are needed at federal, state, and local levels. In 1995, the Public Health Foundation, under contract to the Public Health Services, developed and tested a methodology to estimate expenditures on the essential services.

Given the predominance of personal health services within the public health system and the move of Medicaid beneficiaries to managed care in the private sector, a complementary expenditure estimate is required for personal health services. These periodic estimates of personal health services will allow policy makers to track changes in the relative priorities given to the various health services, in the type of people using public health services, and in the delivery methods for provision of services.

The overall goal of this project is to develop a methodology to collect consistent and complete data on state and local health agency personal health services to improve the decision making process for policy makers, managers and researchers. Specific objectives include:

- to develop categories of personal health services which are sensitive to policy questions under health care reform, taking into account local, state, and federal perspectives;
- to determine the extent to which consistent and complete information can be collected across states using agreed upon common definitions;
- to document the nature of the information sources and the processes for extracting data at the state level; and
- to assess the potential for and level of investment required to obtain data from public health agencies below the state level.

Results of the survey will provide three types of information on:

- bundling of services
- shifts in personal health categories
- shifts in delivery mechanisms

Objectives of the Site Visit

The overall goal of the site visit is to improve the survey methodology by:

- providing state and local health officials an opportunity to discuss in-depth their experiences of working with the survey instrument, including suggestions for improving the methodology

and

- provide project staff with an opportunity to observe the process for collecting data, to obtain source documentation and to discuss barriers to information collection and potential solutions

List of People to Interview - See attached itinerary provided by M. Krenitz

State Health Department - Program/MIS/Accounting
Local Health Department(s) - Program/MIS/Accounting
AHCCCS - Program Overview

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES
RENDERED BY PUBLIC HEALTH AGENCIES

SITE **VISIT** PROTOCOL - ARIZONA

L General

[These **questions are designed to get a general feel for the lay of the land in Arizona, for example, public health system structure, personal health service delivery system, managed care market share, etc.]**

1. **What** is the organizational structure of the health department?

2. What is the relationship between state and local health departments?

3. What, if **any,** is the health department's relationship with managed care organizations (MCOs)? **[Collect** copies **of contracts, if possible.]**

4. **To** whom/what are services contracted out as shown in the survey instrument? Why are these usually contracted out?

5. What is the trend over the last three years in terms of

		1995	1994	1993
Clients	number			
	type			
Budget levels	state			
	local			
Types of service delivery				
	HD delivered			
	Contracted out			
	FFS			
	Capitated			
Uninsured	number			
	access to health care			

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

SITE VISIT PROTOCOL - ARIZONA

6. If the total budget is decreasing, and there has been no change or an increasing number of uninsured, how is this population served?

7. What public personal health care expenditures are not captured by this survey? How should we go about capturing these?

8. Is there a state health report card or other document which describes the needs that are being met by the public health system in terms of personal health services? **[Please provide a copy]**

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

SITE VISIT PROTOCOL - ARIZONA

IL Process (For data collection coordinator)

1. Who/what department coordinated the data collection? Describe the coordination process.

2. Who/what department(s) was/were involved in the data collection? Describe their involvement.

3. **Who** was consulted during the process? Why?

4. Who verified the data? How?

5. How much time was required? (Personhour estimate) (Forms total 21 hours)

6. What mechanism was used to collect multiple local health department data? [Collect copies of correspondence, guidance, tools used, etc.]

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

SITE VISIT PROTOCOL - ARIZONA

IIL Instrument Design (for program managers, accounting)

1. Was the instrument user friendly?

2. Were the categories mutually exclusive/any confusion between categories?
   If not, which ones were not mutually exclusive? [Suggestions for modifying, deleting or adding categories]

3. Were the categories relevant to the work of the health department?
   Which were not, if any?

4. Were the guidelines/instructions detailed enough?
   If not, explain.

5. Were the definitions clear for the personal care categories? Which one(s) were not clear?

6. Were the definitions clear for the delivery mechanisms? Which one(s) were not?

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES
RENDERED BY PUBLIC HEALTH AGENCIES

SITE VISIT PROTOCOL - ARIZONA

IV. Decision Rules (for program managers, accounting)

1. If and where categories were not mutually exclusive, what decision(s) guided assigning of dollars?

2. What assumptions guided the data collection process? Should these assumptions be spelled out in the guidelines?

3. How was general administration handled?

4. Were there problems differentiating bundled (comprehensive services) vs. non-bundled services?

5. Were there problems differentiating bundled personal health vs. bundled primary care?

6. If totals did not agree with the essential public health services expenditure results, what decisions were applied? (see #9 above)

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

SITE VISIT PROTOCOL - ARIZONA

V. **Sources/Reliability (for program managers, accounting)**

1. What were the data sources? [provide documentation, e.g. HD reports, time/cost allocation reports, financial reports, etc.]

2. Were budget or expenditure data used?

3. What source(s) was used to verify the data?

4. What are the most important sources of error/bias?

5. How reliable are the data? Can you estimate the margin of error - + or - X%?

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES
RENDERED BY PUBLIC HEALTH AGENCIES

SITE VISIT PROTOCOL - ARIZONA

VI. Overall Evaluation (All)

1. During completion of data collection, how were questions handled?

2. Would it be possible to collect sources of funds for the various personal health services? If so, what would be necessary?

3. Is there other information which would add to the effectiveness of the survey?

4. Did the survey timing fit in well with department workloads?

5. If not, what is a better time to undertake exercise?

6. Is the data collected useful to the state/local health departments?
   If not, why not?

7. What uses are planned for the data?

   If none, why not?

8. What limitations/problems were encountered during the data collection?

9. What suggestions do you have to improve the process?

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

SITE VISIT PROTOCOL - ARIZONA

VII. Accounting/MIS Systems

Is it possible to add codes to the existing system for categorical programs which would allocate these program expenditures to the ten essential services and automatically generate a separate yearly report on public health expenditures? If yes, provide details and/or demonstration.

MEASURING EXPENDITURES FOR PERSONAL HEALTH CARE SERVICES RENDERED BY PUBLIC HEALTH AGENCIES

SITE VISIT. PROTOCOL - ARIZONA

VHL Queries on Data Submission - Personal Care Survey

1. What percentage of total expenditures do the ADHS data represent?

2. What percentage of local health department expenditures do the counties submitted represent?

3. Maricopa County - EPHS could not reflect Maricopa County which was in excess of $16m, when total for LHDs was just over $13m (where does this figure come from?)

4. What are worksheets at back of some data submissions?

5. Yuma County — No evaluation

6. Pinal County — Used county budget and DARs

7. Pima County -
   Health planning is included as personal health service
   Percentages across rows should add to 100.
   Is this FY94 data, ending 6/30/95
   "Some services did not fit the given structure in a clear manner."
   Budge estimates provided.

8. Mohave County -
   what fiscal year was used? 7/1/94-6/30/95
   Total expenditures = $930,679, not $932,848
   End-of-the-year expenditure figures
   "The weaknesses would be the inappropriate distribution of expense because the cost allocation methodology is not up-to-date nor truly reflective of the true cost expenditures or the interpretation of the definitions is incorrect."
   What is note at end about "General nursing includes but is not limited to: . ..?

9. Gila County -
   What fiscal year was used? 94/95, ending June
   Total expenditures = $306,000, not $276,000

10. Apache County -
    No percentage distribution given
    $26,000 total for whole county - correct?
    Program budgets used

11. ADHS - HIV/STD Services -
    Fiscal year -'95, ending 3/31/96
    Categories are not mutually exclusive
    Figures are estimates -budget figures, not expenditures

12. ADHS - OOH
    Fiscal year, ending September 30
    "Survey is waste of my time, it is an estimate and too confusing."

13. ADHS - OCRS
    No total expenditures given
    Percentages don't add across to 100% on each row
    Fiscal year used?

14. ADHS - BHSD
    No percentage given
    Fiscal year 96, ending 6/30/96
    What is table at back - "Health Planning, Evaluation and Stats?"
    Budget figure given